

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER Lake Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE 817 East Plum Street Moses Lake, WA 98837	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168</p> <p>Based on observation, interview and record review, the facility failed to ensure staff followed safe supervision and handling of two trained staff for mechanical lift transfers for 1 of 3 sample residents (Resident 1), reviewed for mechanical lift transfers. Resident 1 experienced harm when they fell out of the mechanical lift sling while being transferred from their wheelchair to their bed with only one staff person assisting and sustained a laceration to the right side of their head that required hospital evaluation and treatment.</p> <p>Findings included .</p> <p>Review of the 03/01/2024 policy titled Safe Resident Handling/Transfer Equipment showed two trained persons are required to operate a total lift (mechanical lift) intervention for dependent lifting, transferring or repositioning. The goal of the safe handling program is to create a safe environment for staff and residents. Staff who use a mechanical device will ensure the appropriate sling will be used to reposition the resident. Review of the education/training overview showed staff were to be trained in the mechanical lift process on hire to their position, annually and as needed.</p> <p><Resident 1></p> <p>Review of the medical record showed the resident was admitted [DATE] with diagnoses to include severe dementia (cognitive impairment), brain cysts (fluid filled sacs that put pressure on the brain and spine), and mood disorders. Review of the 08/08/2024 annual assessment showed the resident was cognitively impaired, non-verbal and totally dependent on staff for all needs to include transfers from bed to wheelchair. The resident was not able to bear weight or walk on their own. The resident was dependent on staff to transfer by a mechanical lift with a total body sling attached to the lift by staff.</p> <p>During an observation on 10/07/2024 at 11:00 AM, Resident 1 was seated in their wheelchair in the dining room. The resident did not respond to verbal conversation. There was a four-inch suture line of staples in place on the back right side of Resident 1's head.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 505261
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 10/03/2024 investigative report showed Staff C, Nursing Assistant (NA), had transferred Resident 1 from their wheelchair in their body sling that Staff C attached to the mechanical lift bar. Staff C then used the mechanical lift controller while they were guiding the resident by themselves to the bed. During the transfer of Resident 1, one of the sling straps loosened from the mechanical lift bar and the resident fell to the floor. Resident 1 sustained a head laceration and was sent to the hospital.</p> <p>The conclusion of the 10/03/2024 investigation showed the sling loop was not placed completely over the mechanical lift bar hook and resulted in the sling sliding off. Resident 1 fell and hit their head and sustained a head laceration which required an emergency room visit and six staples to the right backside of the resident's head.</p> <p>During an interview on 10/07/2024 at 11:25 AM, Staff C, NA stated that on 10/03/2024 at 8:20 PM Resident 1 was in their wheelchair. Staff C stated they asked Staff F, Licensed Practical Nurse, (LPN) to assist them in transfer of the resident to their bed. Staff C stated the resident had the body sling underneath them while seated in their wheelchair. Staff C hooked the sling to the mechanical lift bar loops two above the resident head and two below the resident knees on both sides of the resident.</p> <p>Additionally, Staff C stated Staff F, LPN, did not assist Staff C with the mechanical lift controls nor did they assist with positioning the body of Resident 1 during transfer with the mechanical lift but stood on the opposite side of Resident 1's bed. Staff C stated Resident 1 who was six feet and one inch tall, began to move and arched their back. The attachment loop from one side of the sling attached to the mechanical lift bar came off. Resident 1 who was in the body sling mid-air fell to the floor, hit the right side of their head and sustained a laceration that required six staples at the hospital.</p> <p>During an interview on 10/07/2024 at 12:30 PM, Staff F, stated they were in Resident 1's room observing Staff C prepare the resident to transfer from their wheelchair to their bed. Staff F stated they did not assist Staff C stated they were just spotting while Staff C transferred the resident. Staff F stated the facility required two staff to be in the room while a mechanical lift was in use for a resident. Staff F stated they were trained to just watch the transfer of a resident but did not participate. Staff F stated that Staff C had Resident 1 parallel to the resident's bed when the sling strap came off the mechanical lift bar and the resident hit their head on the floor. Staff F then called the ambulance and notified the physician and resident's representative.</p> <p>Review of Resident 1's care plan 08/18/2024 intervention showed the resident required assistance of two staff with Hoyer (mechanical lift) transfers.</p> <p>During an interview on 10/07/2024 at 12:10 PM, Staff E, LPN, Staff Development, stated they completed the education for Staff F on Safe Resident Handling/Transfer Equipment and showed Staff F's 06/23/2023 attendance on the education/training requirements. Staff E stated part of the education of insurance of two trained staff be in attendance with mechanical lift transfers was to have both staff have a hands on attention on the resident with one assist with positioning and transfer of the resident and one operated the control of the mechanical lift. Staff needed to be around the resident and not away from the resident with only one staff operating the mechanical lift. transferring the resident. That is not safe transfer.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/07/2024 at 1:15 PM, Staff A, Administrator stated that they understood that it was unsafe practice to have just one staff transfer the resident with a mechanical lift. Staff F, LPN was trained to assist with transfer of Resident 1 with a mechanical lift. Reference WAC 388-97-1060(3)(g)		